- Competitive Bidding - The process by which two or more hospitals, in competition for Medi-Cal business, submit proposed payment rates to the special hospital negotiator.

- Capitation - A method of payment for health services in which a hospital is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person.

- Special Hospital Negotiator - A person appointed by the Governor to negotiate rates, terms, and conditions for contracts with hospitals for inpatient services to be rendered to Medi-Cal program beneficiaries.

- Commission - The California Medi-Cal Assistance Commission is a seven-member commission appointed by the Governor and the Legislature for the purpose of contracting with health care delivery systems for provision of health care services to Medi-Cal recipients. The negotiator serves as the executive director of the commission.

- Block Grant Payment - A method of payment for health services in which a hospital is paid a fixed sum to provide a defined set of services to a defined set of beneficiaries for a fixed period of time.

- Prepayment - A method of payment for health services in which the terms of the payment are established in advance of providing services.

- Retrospective Payment - A method of payment for health services in which a hospital is paid after providing services.

III. Rate Setting Method

Hospitals in a geographic area will be notified of the opportunity to contract for the provision of inpatient services for Medi-Cal beneficiaries. The special hospital negotiator (in FY 82-83) or the commission (in subsequent years) will negotiate with, seek competitive bids from, and/or use other procurement methods with those hospitals which express an interest in participating in the Medi-Cal program. Factors to be considered will include, but are not limited to: (a) beneficiary access; (b) utilization controls; (c) ability to render quality services efficiently and economically; (d) demonstrated ability to provide or arrange needed specialty services; (e) protection against fraud and abuse; (f) any other factor which would reduce costs, promote access, or enhance the quality of care; (g) the capacity to provide a given tertiary service, such as specialized children's services, on a regional basis; (h) recognition of the variations in severity of illness and complexity of care; and (i) existing labor-management collective bargaining agreements. The situation of hospitals which serve a disproportionate number of low income patients with special needs will be taken into account in establishin rates under the contracting process.

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Payment to contracting hospitals may be on a capitation or prepayment basis, or on a combination of both methods of payment, or using other methods of payment, such as retrospective or block grant, that the special hospital negotiator or the California Medical Assistance Commission determines to be feasible.

The hospital negotiator or the commission will select the most cost-effective hospitals and will contract with a sufficient number of hospitals to provide adequate bed capacity for Medi-Cal patients in an area. Hospitals' willingness to enter into contracts assures the reasonableness and adequacy of rates to meet the costs of efficiently and economically operated providers.

The process of contracting for a sufficient number of hospitals to provide adequate bed capacity for Medi-Cal patients will be based on an assessment of the Medi-Cal patient needs. The types and amounts of inpatient hospital services historically rendered to Medi-Cal patients in each Health Facility Planning Area (HFPA) in the State will be evaluated. Projections of service needs for patients within each HFPA will be established. Required bed capacity will then be contracted for with sufficient numbers of hospitals to render care to Medi-Cal patients in those HFPAs. Some hospital capacity projected to be needed by patients in one HFPA may be contracted for in another HFPA so long as the normal community travel practices are considered and provided for.

Hospitals may assume all or part of the risk for utilization of services, or cost of services, or both.

Hospitals located in areas where the process has been implemented and which do not contract to provide Medi-Cal services will be reimbursed for emergency services at rates developed using cost-based reimbursement as defined in this State Plan. Additionally, reimbursement for hospital patients receiving services at an inappropriate level of care as specified in 42 CFR 447.252(a)(ii) (Administrative Days) shall be at the same rate as previously provided for in the State Plan.

For further details on the contracting process, see Federal Waiver Request, California's Selective Contracting Program, August 27, 1982 which is incorporated herein by reference.

IV. Appeals and Exemptions

A. Appeals

Judicial review pursuant to Section 1085 of the California Code of Civil Procedures shall be available to resolve disputes relating to the terms, performance, or termination of contracts, or any act, failure to act, conduct, order, or decision of the Special Hospital Negotiator and the California Medical Assistance

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Commission. Civil Code Section 1085 is California's mandamus action which is available to compel the performance of a mandatory duty to act, to control abuse of discretion and to control actions in excess of jurisdiction. This is a frequently used judicial remedy to set aside State actions. While Welfare and Institutions Code Section 14087.2 explicitly authorizes a Civil Code 1085 action for the above stated reasons, a code of Civil Procedure 1085 action would also be available to any hospital which does not receive a contract if they can demonstrate that the negotiator abused his discretion by arbitrarily rejecting their offer or bid, or by demonstrating that the contracting process was implemented in an arbitrary manner. Venue for judicial review will only be in counties in which the Attorney General maintains an office.

As an alternative to the remedy provided under CCP Section 1085 contracts with hospitals will also provide for administrative review of disputes relating to performance under the contract. The proceedings for review of such disputes will be conducted by an independent hearing examiner who will render a proposed decision. The final decision will be rendered by the Director of the Department of Health Services.

Administrative review pursuant to Welfare and Institutions Code Section 14171 will be provided for recoupment efforts based on an audit or review of the hospital and for performance of the terms and conditions of the negotiated contract. This is the same administrative appeal procedure currently used to appeal audits of cost reports.

B. Exemptions

The hospital contracting requirements will not apply to:

(1) Emergency Services

Non-contracting hospitals will be reimbursed using cost-based reimbursement for services to program beneficiaries in life threatening emergency situations, or emergency situations that could result in permanent impairment.

(2) HMOs

Contracting provisions will not apply to hospital inpatient services rendered by health maintenance organizations and other organized health systems.

(3) State Hospitals

Contracting provisions will not apply to hospital inpatient services rendered to Medi-Cal beneficiaries by the State-owned and operated hospitals for the mentally disordered and developmentally disabled.

(4) Children's Hospitals

In FY 82-83, children's hospitals and the City of Hope, a charitable research hospital, will not be required to contract with the Medi-Cal program. Services provided by such hospitals will be reimbursed on the same basis that they were reimbursed on June 30, 1982. Children's hospitals are defined as those hospitals where 30 percent of the infants and children served by the single institution qualify for Medi-Cal payment systems and the institution serves primarily children.

If such a hospital elects to enter into a contract with the Medi-Cal program, the negotiator and the commission will give consideration to the special services provided to children.

(5) Out-of-State

Out-of-state hospitals who serve Medi-Cal beneficiaries will be exempt from the contracting program. These hospitals will be reimbursed using cost-based reimbursement.

(6) Beneficiaries with Excessive Travel Burden

If the distance from a beneficiary's home to a contract facility exceeds the normal practice for the community for travel time, the beneficiary will not be restricted to contract facilities if the hospital providing service is closer than a contract facility. In most areas of the state (urban and suburban), 30 minutes driving time may be considered the guideline for the normal community practice.

(7) Medicare Part A Crossover Patients

Hospital inpatient services provided to Medi-Cal beneficiaries who are also eligible for benefits under the federal program of hospital insurance for the aged and disabled (Medicare Part A) will be exempt from the contracting program. Medi-Cal will continue to reimburse for the Part B premiums, co-insurance, and deductible for all Medicare crossover beneficiaries. When Medicare Part A crossover beneficiaries have exhausted all Medicare inpatient benefits they will be transferred, if medically feasible, to a contract facility.

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V. Cost Reporting

All hospitals under the Medi-Cal program are and will continue to be required to submit uniform Medi-Cal cost reports.

VI. Audits

The Department or its authorized agents will conduct periodic audits or reviews, including on-site reviews, of performance under the contract in order to assure that only quality, efficient and economic services are provided under the contract. Such audits or reviews will evaluate the following:

A. Level and quality of care, and the necessity and appropriateness of the services provided.

B. Internal procedures for assuring efficiency, economy, and quality of care.

C. Grievances relating to medical care and their disposition.

D. Financial records when determined necessary by the Department to protect public funds.

In addition, procedures necessary to audit the specific terms and conditions of signed contracts will be utilized.

VII. Upper Limits

Reimbursement to inpatient hospital providers under the Selective Provider Contracting Program will not provide payments in the aggregate which are more than a provider's customary charges to the general public for the services. Payments to all providers will be no more than the aggregate amount that would be paid for services under Medicare principles of reimbursement.

VIII. Regulations

Administrative regulations which implement, interpret, and make specific provisions of this plan will be adopted in accordance with the public notice and hearing requirements of California's Administrative Procedure Act regarding emergency regulations. Any interested person may also petition a State agency requesting the adoption, amendment, or repeal of a regulation as provided in the Act.

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10-1-82

From: Peggy Rahn
To: SAN FRANCISCO.SFO1(SYee)
Date: 6/27/97 7:54am
Subject: California Hospital State Plan Housekeeping -Reply -Reply

Sharon,

Thanks for the material . The 93-09 pages 38-40 and the 92-14 approval pkg. clear up things from our end.

The six mystery pages at the end of our 4.19A section may just have been inserted for reference purposes so that anyone looking at the plan would be aware of the 1915(b) waiver. However, the heading on the first page reads: ATTACHMENT 4.19A: DESCRIPTION OF METHODS AND STANDARDS USED TO DETERMINE RATES FOR PAYMENT OF HOSPITAL INPATIENT SERVICES. Each page has the mark of a stamp re: transmittal #; _82-12_; REC'D FO_7-13-82_; APPROVED_10-28-82_; & EFFECTIVE_10/1/82_: I'll fax them to you.

From: Sharon Yee
To: BALT2.CO2(PRahn)
Date: 6/26/97 1:00pm
Subject: California Hospital State Plan Housekeeping -Reply

see below

>>> Peggy Rahn 06/25/97 02:05pm >>>
Sharon,

Thanks for the 95-016 approval package. In filing the amendment pages 41-45, I realized that our version of the 4.19-A section of the plan ends with page 37B of the DSH section. That is followed by six un-numbered pages describing the Selective Provider Contracting Program (SPCP). What does your copy of the state's plan show between pages 37B and page 41 of TN 95-016? **Our Attachment 4.19-A has pages 38-40 from SPA 93-009, approved 7/22/94. I have nothing after page 45. I don't see anything regarding the SPCP which is a 1915(b) waiver program. Please call (415-744-2935) so I can track down the SPCP pages.**

Also,

Our pending files still contain TN 92-014 re: changes in the inp. hospital reimbursement methodology for out-of-state hospitals (proposed as page 59) , with a Request for Additional Information letter going out 1/21/93. However, page 16 of the currently approved plan dealing with the same subject & containing essentially the same text, was approved 12/7/93 as TN 92-14. Do your files show a 92-14 response which changed page 59 to page 16? **Yes, SPA 92-14 was approved 12/7/93. I'll fax you a copy of this SPA and pages 38-40 of Att. 4.19-A.**

Perhaps our files were just not updated as they should have been. This is not urgent, but when you have a moment, any light you can shed will be appreciated.

Thanks for your help.

CC: lnetzer, imclean, rstrimling